

**MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN
SERVICES**

Quality Assurance Division-Licensure Bureau

2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953
FAX: (406) 444-1742

**APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY/SERVICE LICENSE
OUTDOOR BEHAVIORAL PROGRAM APPLICATION**

Initial Application ☐

Renewal Application ☐

Facility Name: _____

Facility Address: _____ PO Box: _____

City: _____ State/Zip: _____ County: _____

Facility Telephone Number: _____ FAX: _____

Facility E-mail/Web page Address: _____

Name of Applicant: _____

Applicant Address: _____ City: _____ State/Zip: _____

Applicant (or contact) e-mail address: _____

Name of Administrator: _____

Administrator Address: _____ City: _____ State/Zip: _____

Administrator e-mail: _____

Administrator Qualifications (ARM 37.98.401)

(use additional sheets if necessary)

Owner (If different from Applicant): _____

Owner Address: _____ City: _____ State/Zip: _____

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Name and Address of Management Company if different from owner:

Floor Plan is: ☐ **New Construction** ☐ **Existing Structure** ☐ **Addition** ☐ **Remodeled**

Information on ownership, contract, or lease agreement if operated by a person other than the owner:

- ☐ **A partnership, firm or association--List every member thereof.**
- ☐ **A corporation--List the name and address thereof and the names of its officers.**
- ☐ **State Affiliated Organization**

Name	Address

(Please attach additional sheets as needed.)

List the Names and Addresses of the Governing Body:

Name	Address

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Age Range of Youth to be Served []

Number of Males [] Number of Females []

Does the Program offer Residential Outdoor Services [] Yes [] No

Expedition Site:

I certify that all information submitted to DPHHS is true and correct. This license application for an Outdoor Behavioral Program is hereby submitted under the provision of Section 50-5-101 through 50-5-228.

SIGNED: _____

DATE: _____

TITLE: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

Enclose a check, money order or draft made payable to the Department of Public Health & Human Services to cover the license fee. The fee is determined as follows:

(a) facilities with 20 or less = \$20.00

(b) facilities with 21 beds or more = \$1.00 per bed.

This fee will be deposited in the State Treasury and is non-refundable.